

		FOR OHF USE					

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**2001**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2001)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0038174</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Maryville Manor</u>		<b>I have examined the contents of the accompanying report to the</b> <b>State of Illinois, for the period from</b> <u>7/1/01</u> <b>to</b> <u>12/31/01</u> <b>and certify to the best of my knowledge and belief that the said contents</b> <b>are true, accurate and complete statements in accordance with</b> <b>applicable instructions. Declaration of preparer (other than provider)</b> <b>is based on all information of which preparer has any knowledge.</b>	
<b>Address:</b> <u>700 Vandalahene Drive</u> <u>Maryville</u> <u>62062</u> Number City Zip Code		<b>Intentional misrepresentation or falsification of any information</b> <b>in this cost report may be punishable by fine and/or imprisonment.</b>	
<b>County:</b> <u>Madison</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____	
<b>Telephone Number:</b> <u>(618) 288-5999</u> <b>Fax #</b> <u>(618) 288-1106</u>		(Type or Print Name) <u>Ron Wilson</u>	
<b>IDPA ID Number:</b> <u>37-1223745005</u>		(Title) <u>Chief Financial Officer</u>	
<b>Date of Initial License for Current Owners:</b> <u>12/02/91</u>		<b>Paid Preparer</b> (Signed) <u>See Independent Accountant's Report</u> (Date) _____	
<b>Type of Ownership:</b>		(Print Name and Title) <u>McGladrey &amp; Pullen, LLP</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		(Firm Name & Address) <u>117 East Main, Suite 210, P.O. Box 1070</u> <u>Galesburg, Illinois 61402</u>	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>(309) 342-1175</u> <b>Fax #</b> <u>(309) 342-7816</u>	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Ron Wilson</u> <b>Telephone Number:</b> <u>(309) 343-1550</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Maryville Manor# 0038174 Report Period Beginning: 1/1/01 Ending: 12/31/01

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,963</u>	<u>251</u>	<u>2,468</u>	<u>8,682</u>	8
9	SNF/PED					9
10	ICF	<u>11,927</u>	<u>14,623</u>	<u>0</u>	<u>26,550</u>	10
11	ICF/DD					11
12	SC			<u>0</u>		12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,890</u>	<u>14,874</u>	<u>2,468</u>	<u>35,232</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 80.44%

D. How many bed-hold days during this year were paid by Public Aid?

24 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/02/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 10/04/91 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 14 and days of care provided 2,468Medicare Intermediary AdminaStar Federal Inc.

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

Maryville Manor

# 0038174

Report Period Beginning:

1/1/01

Ending:

12/31/01

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	177,054	11,251	6,600	194,905		194,905		194,905		1
2	Food Purchase		152,555		152,555		152,555	(1,408)	151,147		2
3	Housekeeping	92,233	23,810	3,448	119,491		119,491		119,491		3
4	Laundry	61,228	19,588		80,816		80,816		80,816		4
5	Heat and Other Utilities			102,544	102,544		102,544	325	102,869		5
6	Maintenance	25,747	19,053	37,431	82,231		82,231	467	82,698		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	356,262	226,257	150,023	732,542		732,542	(616)	731,926		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,500	9,500		9,500		9,500		9
10	Nursing and Medical Records	1,189,303	143,853	1,214	1,334,370		1,334,370		1,334,370		10
10a	Therapy	75,713		8,397	84,110		84,110		84,110		10a
11	Activities	49,789	3,856	83	53,728		53,728		53,728		11
12	Social Services	24,521			24,521		24,521		24,521		12
13	Nurse Aide Training										13
14	Program Transportation			2,354	2,354	902	3,256		3,256		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,339,326	147,709	21,548	1,508,583	902	1,509,485		1,509,485		16
	<b>C. General Administration</b>										
17	Administrative	70,657			70,657		70,657	82,483	153,140		17
18	Directors Fees										18
19	Professional Services			177,696	177,696		177,696	(153,115)	24,581		19
20	Dues, Fees, Subscriptions & Promotions			130,046	130,046		130,046	(40,301)	89,745		20
21	Clerical & General Office Expenses	36,016	21,382	23,068	80,466		80,466	7,064	87,530		21
22	Employee Benefits & Payroll Taxes			251,432	251,432		251,432	13,135	264,567		22
23	Inservice Training & Education			2,692	2,692		2,692		2,692		23
24	Travel and Seminar			3,314	3,314		3,314	2,636	5,950		24
25	Other Admin. Staff Transportation			1,804	1,804	(902)	902	3,198	4,100		25
26	Insurance-Prop.Liab.Malpractice			53,244	53,244		53,244	235	53,479		26
27	Other (specify):* See Attached Sch VI			13,755	13,755		13,755	(13,755)			27
28	<b>TOTAL General Administration</b>	106,673	21,382	657,051	785,106	(902)	784,204	(98,420)	685,784		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,802,261	395,348	828,622	3,026,231		3,026,231	(99,036)	2,927,195		29

\* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Maryville Manor

#0038174

Report Period Beginning:

1/1/01

Ending:

12/31/01

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			19,646	19,646		19,646	135,859	155,505			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			851	851		851	108,628	109,479			32
33	Real Estate Taxes			73,100	73,100		73,100	287	73,387			33
34	Rent-Facility & Grounds			415,949	415,949		415,949	(412,040)	3,909			34
35	Rent-Equipment & Vehicles			165	165		165	656	821			35
36	Other (specify):* <b>Amortization</b>							3,060	3,060			36
37	<b>TOTAL Ownership</b>			509,711	509,711		509,711	(163,550)	346,161			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			7,656	7,656		7,656		7,656			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,702	65,702		65,702		65,702			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			73,358	73,358		73,358		73,358			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,802,261	395,348	1,411,691	3,609,300		3,609,300	(262,586)	3,346,714			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryville Manor# 0038174

Report Period Beginning:

1/1/01

Ending:

12/31/01

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(261)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,524	30		9
10	Interest and Other Investment Income	(42,146)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,147)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,227)	27		24
25	Fund Raising, Advertising and Promotional	(31,962)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(8,353)	20		28
29	Other-Attach Schedule See Attached Schedule VII	(1,804)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (94,376)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense		31	33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(168,210)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (168,210)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (262,586)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Maryville Manor

ID# 0038174

Report Period Beginning: 1/1/01

Ending: 12/31/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Maryville Manor# 0038174

Report Period Beginning:

1/1/01

Ending:

12/31/01

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,408)	0	0	0	0	0	0	0	0	0	0	(1,408)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,408)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,408)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(34,230)	0	0	0	0	0	0	0	0	0	(34,230)	19
20	Fees, Subscriptions & Promotions	(40,315)	0	0	0	0	0	0	0	0	0	0	(40,315)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(13,227)	0	0	0	0	0	0	0	0	0	0	(13,227)	27
28	<b>TOTAL General Administration</b>	<b>(53,542)</b>	<b>(34,230)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(87,772)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(54,950)</b>	<b>(34,230)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(89,180)</b>	<b>29</b>

## Summary B

12/31/01

[illegible]



Facility Name & ID Number Maryville Manor# 0038174

Report Period Beginning:

1/1/01

Ending:

12/31/01

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Illini Manors, Inc.</u>	<u>100%</u>	<u>See Attached Schedule I</u>		<u>RFMS, Inc.</u>	<u>Galesburg</u>	<u>Admin. Svcs.</u>
<u>(100% owned by Don Fike)</u>						
				<u>L B Properties, Inc.</u>	<u>Galesburg</u>	<u>Lessor</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V	<u>34 Facility Rental</u>	<u>415,949</u>	<u>L B Properties, Inc.</u>	<u>None</u>	<u>281,969</u>	<u>(133,980)</u>	2
3	V			<u>(77.6% owned by Don Fike)</u>				3
4	V							4
5	V	<u>19 Administrative Services</u>	<u>156,000</u>	<u>RFMS, Inc.</u>	<u>None</u>	<u>121,770</u>	<u>(34,230)</u>	5
6	V			<u>(100% owned by Don Fike)</u>				6
7	V							7
8	V							8
9	V			<u>See Attached Schedules III and IV</u>				9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>571,949</u>			\$ <u>403,739</u>	\$ * <u>(168,210)</u>	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryville Manor # 0038174 Report Period Beginning: 1/1/01 Ending: 12/31/01

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2	Don Fike	President	Management	100.00	See Attached	>40	100.00	Salary	8,686	17-7	2
3					Schedule III			Benefits	585	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,271		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryville Manor # 0038174 Report Period Beginning: 1/1/01 Ending: 12/31/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2	Bank One, Springfield		x	Refinanced building mortgage	Varies Pd	05/09/96	2,847,515	2,154,498	04/01/11	6.6600	150,623	2	
3					Quarterly							3	
4	Interest Income Adjustment			From page 5, line 10							(42,146)	4	
5												5	
	Working Capital												
6												6	
7	Miscellaneous Vendors		x	Miscellaneous operating							851	7	
8	Home Office Allocation Adj.			See Attached Schedule III							151	8	
9	TOTAL Facility Related						\$ 2,847,515	\$ 2,154,498			\$ 109,479	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,847,515	\$ 2,154,498			\$ 109,479	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Maryville Manor**# **0038174**

Report Period Beginning:

**1/1/01**

Ending:

**12/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.	\$	<b>75,456</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>74,256</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(1,200)</b>	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>74,300</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>73,100</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996	<b>67,241</b>	8
	1997	<b>69,146</b>	9
	1998	<b>70,728</b>	10
	1999	<b>72,985</b>	11
	2000	<b>74,257</b>	12
<b>Real estate tax accrual is based on estimated tax expense. The lessee, by terms of the lease agreement, is required to pay the applicable real estate taxes.</b>			

	<b>FOR OHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2000	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Maryville Manor COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0038174

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE ( 309 ) 343-1550 FAX #: ( 309 ) 343-2857

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-1-21-02-00-000-012.009</u>	<u>L B Properties, Inc.</u>	\$ <u>74,257.00</u>	\$ <u>74,257.00</u>
2. _____	<u>PT W PT SE</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>74,257.00</u>	\$ <u>74,257.00</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES       X       NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,907
 B. General Construction Type:
 Exterior Brick
 Frame Wood
 Number of Stories 1

C. Does the Operating Entity?
 (a) Own the Facility
 (b) Rent from a Related Organization.
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 (a) Own the Equipment
 (b) Rent equipment from a Related Organization.
 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES
 NO
 If so, please complete the following:

1. Total Amount Incurred: N/A
 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A
 4. Dates Incurred: N/A

Nature of Costs: N/A

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	6.5 Acres	1991	\$ 81,250	1
2					2
3	TOTALS			\$ 81,250	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Maryville Manor

# 0038174

Report Period Beginning:

1/1/01

Ending:

12/31/01

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	110			1991	\$ 2,287,110	\$ 72,607	31	\$ 72,607	\$	\$ 744,058	4
5	10			1996	353,889	14,156	25	14,156		71,960	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	<b>Total improvements by year constructed:</b>										
10	1991			1991	115,420	7,695	15	7,695		78,874	10
11	1992			1992	1,100	65	10	110	45	1,027	11
12	1993			1993	6,587		7			6,587	12
13	1995			1995	11,477	678	40	287	(391)	2,009	13
14	1997			1997	49,481	3,666	8-20	4,126	460	19,585	14
15											15
16	<b>Detailed improvements for the years 1998 - 2001:</b>										
17	None										17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT



XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)	\$ 2,825,064	\$ 98,867		\$ 98,981	\$ 114	\$ 924,100		70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 570,323	\$ 41,773	\$ 46,838	\$ 5,065	5-15 yrs	\$ 528,612	71
72	Current Year Purchases	13,027	2,175	1,085	(1,090)	5-10 yrs	1,085	72
73	Fully Depreciated Assets							73
74	Indirect Costs Allocated (See Attached Schedule III)		3,049	3,049				74
75	TOTALS	\$ 583,350	\$ 46,997	\$ 50,972	\$ 3,975		\$ 529,697	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	Van	1993	\$ 4,298	\$	\$	\$	5 yrs	\$ 4,298	76
77	Patient Care	1997 Eldorado Bus	1997	44,413	5,117	5,552	435	4 yrs	44,413	77
78										78
79										79
80	TOTALS			\$ 48,711	\$ 5,117	\$ 5,552	\$ 435		\$ 48,711	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,538,375	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 150,981	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 155,505	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,524	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,502,508	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**Ending:** 12/31/01

**A. Building and Fixed Equipment (See instructions.)**

**2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?**

☒ YES      ☐ NO

14. \_\_\_\_\_/2004 \$ \_\_\_\_\_

**9. Option to Buy:** ☐ **YES** ☐ **NO** **Terms:** \_\_\_\_\_\*

☐ YES ☐ NO

**(Attach a schedule detailing the breakdown of movable equipment)**

**\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>All nurse aides have met training requirements.</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>          </u></p>
--	--	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language Development Therapist		hrs								2
2	Licensed Recreational Therapist		hrs								3
3	Licensed Physical Therapist		hrs								4
4	Physician Care		visits								5
5	Dental Care		visits								6
6	Work Related Program		hrs								7
7	Habilitation		hrs								8
8			# of prescrpts								9
9	Pharmacy										
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
10	Academic Education		hrs								11
11	Exceptional Care Program										12
12											
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 37,825	\$ 119,080	1
2	Cash-Patient Deposits	1,397	1,397	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	585,653	1,011,448	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	135,701	163,192	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		1,574,571	8
9	Other(specify): See Attached Schedule VIII	2,577,451	2,577,451	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 3,338,027	\$ 5,447,139	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		104,078	12
13	Land		81,250	13
14	Buildings, at Historical Cost		2,640,999	14
15	Leasehold Improvements, at Historical Cost	68,645	318,875	15
16	Equipment, at Historical Cost	180,559	1,250,536	16
17	Accumulated Depreciation (book methods)	(185,917)	(2,121,246)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Financing Costs			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 63,287	\$ 2,274,492	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,401,314	\$ 7,721,631	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 69,080	\$ 103,370	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,397	1,397	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	124,554	250,506	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,172	3,172	31
32	Accrued Real Estate Taxes(Sch.IX-B)	74,300	80,186	32
33	Accrued Interest Payable		11,957	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Interdivision Payable			36
37	Other Accrued Liabilities			37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 272,503	\$ 450,588	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,154,498	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44	Resident Security Deposits	75,000	75,000	44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 75,000	\$ 2,229,498	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 347,503	\$ 2,680,086	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 3,053,811	\$ 5,041,545	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,401,314	\$ 7,721,631	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 2,416,162</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Year-end adjustments made subsequent to the filing of the</b>		<b>3</b>
<b>4</b>	<b>prior year's Medicaid cost report. (See Attached Schedule IX)</b>		<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 2,416,162</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>637,649</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 637,649</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Interdivision transfers</b>		<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 3,053,811</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,186,853	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,186,853	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	44,290	6
7	Oxygen	6,207	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 50,497	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	8,616	13
14	Non-Patient Meals	261	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 8,877	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	404	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 404	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Activity Fund Income</b>		28
28a	<b>Durable Medical Equipment</b>	318	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 318	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,246,949	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	732,542	31
32	Health Care	1,508,583	32
33	General Administration	785,106	33
<b>B. Capital Expense</b>			
34	Ownership	509,711	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	7,656	35
36	Provider Participation Fee	65,702	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,609,300	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	637,649	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 637,649	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. See Attached Schedule V

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



Facility Name & ID Number Maryville Manor# 0038174Report Period Beginning: 1/1/01Ending: 12/31/01

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,697	1,805	\$ 41,214	\$ 22.83	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,059	8,574	154,673	18.04	3
4	Licensed Practical Nurses	17,153	18,248	275,003	15.07	4
5	Nurse Aides & Orderlies	68,598	72,976	595,486	8.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	697	741	25,478	34.38	7
8	Rehab/Therapy Aides	2,498	2,658	50,235	18.90	8
9	Activity Director	1,717	1,826	20,091	11.00	9
10	Activity Assistants	4,467	4,752	29,698	6.25	10
11	Social Service Workers	2,071	2,203	24,521	11.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,044	23,451	177,054	7.55	15
16	Dishwashers					16
17	Maintenance Workers	1,936	2,060	25,747	12.50	17
18	Housekeepers	12,511	13,309	92,233	6.93	18
19	Laundry	8,005	8,516	61,228	7.19	19
20	Administrator	1,955	2,080	45,185	21.72	20
21	Assistant Administrator	1,955	2,080	25,472	12.25	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,404	3,621	36,016	9.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,108	2,243	25,230	11.25	31
32	Other Health Care Supervisors	9,822	10,449	97,697	9.35	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	170,697	181,592	\$ 1,802,261 *	\$ 9.92	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	***	\$ 6,600	1-3	35
36	Medical Director	***	9,500	9-3	36
37	Medical Records Consultant	***	314	10-3	37
38	Nurse Consultant	***		10-3	38
39	Pharmacist Consultant	***	900	10-3	39
40	Physical Therapy Consultant	***	8,397	10a-3	40
41	Occupational Therapy Consultant	***	0	10a-3	41
42	Respiratory Therapy Consultant	***		10a-3	42
43	Speech Therapy Consultant	***	0	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***	0	12-3	45
46	Other(specify) Dental Consultant	***	0	10-3	46
47	Psychological Consultant	***		10-3	47
48	***=Monthly Fee Arrangement				48
49	TOTAL (lines 35 - 48)		\$ 25,711		49

## C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Maryville Manor

# 0038174

Report Period Beginning: 1/1/01

**Ending:** 12/31/01

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description		Amount	
Jo Thompson	Administrator	None	45,185	Workers' Compensation Insurance		26,130	IDPH License Fee		400	
Marsha Christensen	Asst. Admin.	None	25,472	Unemployment Compensation Insurance		22,539	Advertising: Employee Recruitment		80,364	
				FICA Taxes		136,672	Health Care Worker Background Check (Indicate # of checks performed <u>179</u> )		2,148	
				Employee Health Insurance		47,540	IHCA Dues		5,962	
				Employee Meals			Subscriptions & Fees		651	
				Illinois Municipal Retirement Fund (IMRF)*			Other Licenses		206	
				401(k) Plan Contributions		8,186	Advertising - Promotional		31,962	
				Other Employment Benefits		6,207	Advertising - Yellow Pages		8,353	
				Employee Appreciation		4,158	Indirect Costs - See Attached Sch III		14	
							Less: Public Relations Expense		(	
							Non-allowable advertising		(31,962)	
							Yellow page advertising		(8,353)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 70,657				TOTAL (agree to Sch. V, line 20, col. 8)		\$ 89,745	
B. Administrative - Other										
Description			Amount							
			\$							
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$							
C. Professional Services								G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description		Line #	Amount	Description		Amount
			\$				\$	Out-of-State Travel		\$
RFMS, Inc.	Administrative Services		156,000							
McGladrey & Pullen, LLP	Accounting Services		12,179							
Systematic Management	Collections Consultant		9,212							
Davis & Campbell, LLC	Legal Fees		255					In-State Travel		
Brown, Hay & Stephens	Legal Fees		50					Staff use of personal vehicle on facility business and meals (under \$250 per travel voucher)		716
								Seminar Expense		2,598
								Less out-of-state training		(1,276)
								Indirect Costs - See Attached Sch. III		3,912
								Entertainment Expense		(
								(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 177,696	TOTAL			\$	TOTAL		\$ 5,950

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	None												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maryville Manor

STATE OF ILLINOIS

# 0038174

Report Period Beginning:

1/1/01

Ending:

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12/31/01

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. See page 21, Section F
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 6 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,334 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,702  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 261
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: McGladrey & Pullen, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet completed.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

FACILITY NAME: Maryville ManorYEAR ENDED: 12/31/01**COST REPORT GROUPINGS**  
**DATA INPUT SHEET**

<b>Cost Center</b>	<b>Cost Type</b>	<b>Grouping Code</b>	<b>\$ Amount</b>	<b>Balance Sheet</b>	<b>Grouping Code</b>	<b>\$ Amount</b>
Dietary	Labor	1-1	177,054	Cash	A1	37,825
Dietary	Supplies	1-2	11,251	Patient Deposits	A2	1,397
Dietary	Other	1-3	6,600	Accounts Receivable	A3	585,653
Nursing	Labor	10-1	1,189,303	Prepaid Insurance	A6	135,701
Nursing	Supplies	10-2	143,853	Other Prepaid Exp	A7	0
Nursing	Other	10-3	1,214	Related Party Rec'ble	A8	0
Therapy	Labor	10A-1	75,713	Interdivision Receivable	A9	2,577,451
Therapy	Other	10A-3	8,397	Interest Receivable	A9a	0
Activities	Labor	11-1	49,789	Long-Term Investments	B12	0
Activities	Supplies	11-2	3,856	Land	B13	0
Activities	Other	11-3	83	Buildings	B14	0
SocSerDir	Labor	12-1	24,521	Leasehold Improve	B15	68,645
SocSerDir	Other	12-3	0	Equipment	B16	180,559
NurseAideTrng	Labor	13-1	0	Accum Depreciation	B17	(185,917)
NurseAideTrng	Supplies	13-2	0	Deferred Maintenance	B18	0
NurseAideTrng	Other	13-3	0	Org & Pre-Op Costs	B19	0
ProgramTransp	Other	14-3	2,354	Accum Amortization	B20	0
Administrative	Labor	17-1	70,657	Loan Financing Costs	B23a	0
Prof. Services	Other	19-3	177,696	Leasehold Deposit	B23b	0
FoodPurchase	Supplies	2-2	152,555			
Fees,Subs&Promo	Other	20-3	130,046	Total Assets		3,401,314
Clerical&GO	Labor	21-1	36,016			
Clerical&GO	Supplies	21-2	21,382	Accounts Payable	C26	69,080
Clerical&GO	Other	21-3	23,068	A/P-Patient Deposits	C28	1,397
EmployeeBen	Other	22-3	251,432	Accrued Salaries	C30	124,554
Inservice Training	Other	23-3	2,692	Accrued Taxes	C31	3,172
Travel	Other	24-3	716	AccrRealEstateTax	C32	74,300
Seminar	Other	24-3a	2,598	Accrued Interest	C33	0
Admin Staff Transp	Other	25-3	1,804	Interdivision Payable	C36	0
Insurance	Other	26-3	53,244	Other Current Liab	C37	0
Bad Debts	Other	27-3	13,227	Mortgage Payable	D40	0
Lobbying	Other	27-3a	528	Security Deposits	D44	75,000
Housekeeping	Labor	3-1	92,233	Retained Earnings	E1	2,416,162
Housekeeping	Supplies	3-2	23,810	Distributions	E13	0
Housekeeping	Other	3-3	3,448	Transfers	E18	0
Depreciation	Other	30-3	19,646	Total Liab & Equity		2,763,665
Amort of Pre-Op	Other	31-3	0			
Interest	Other	32-3	851	Net Income(Loss)		637,649
RealEstateTax	Other	33-3	73,100	Ending RE		3,053,811
Rent-Facility	Other	34-3	415,949			
Rent-Equip&Vehicle	Other	35-3	165	Gross Revenue	R1	4,186,853
Amortization	Other	36-3	0	NurseAideTrngReimb	R11	0
Ancillary	Labor	39-1	0	Vending	R12	0
Ancillary	Other	39-3	7,656	Barber & Beauty	R13	8,616
Laundry	Labor	4-1	61,228	Non-Patient Meals	R14	261
Laundry	Supplies	4-2	19,588	Telephone & TV	R15	0
Vending	Other	41-3	0	Non-Patient Supplies	R18	0
ProvParticFee	Other	42-3	65,702	Contributions	R24	0
Utilities	Other	5-3	102,544	Interest	R25	404
Maintenance	Labor	6-1	25,747	Recoveries	R28	0
Maintenance	Supplies	6-2	19,053	Durable Med Equip	R28a	318
Maintenance	Other	6-3	37,431	Gain(loss)-equipment	R28b	0
MedicalDirector	Other	9-3	9,500	Outpatient Services	R5	0
				Therapy	R6	44,290
				Oxygen	R7	6,207
				Income Tax (expense)	R42	0
				Total Revenue		4,246,949
				Total Costs		3,609,300
				Net Income(Loss)		637,649
				Input Error (s/b -0-)		0

**OTHER INFORMATION**  
**DATA INPUT SHEET**

SALARY COSTS		Page 20 Line/Amt	
10-1	4000	41,214	1
	4005	0	2
	4006	45,688	32
	4007	2,151	32
	4008	25,230	31
	4010	120,738	3
	4011	33,935	3
	4015	255,791	4
	4016	19,212	4
	4018	49,858	32
	4020	483,768	5
	4021	0	32
	4022	227	5
	4023	51,892	5
	4024	40,826	5
	4025	18,666	5
	4026	107	5
10A-1	4050	7,336	7
	4051	37,602	8
	4052	0	8
	4055	8,461	7
	4056	12,633	8
	4060	9,681	7
11-1	2000	20,091	9
	2005	29,698	10
17-1	8000	45,185	20
	8005	25,472	21
Total		1,385,462	
		1,385,462	
CONSULTANT SERVICES		Pg 20 Ln/Amt	
10-3	4400	900	39
	4425	0	46
	4455	314	37
10A-3	4550	0	40
	4551	0	40
	4552	0	40
	4575	0	41
	4576	0	41
	4577	0	41
	4600	0	43
	4601	0	43
	4602	0	43
	4650	8,397	40
Total		9,611	
		9,611	

CENSUS INFORMATION (days)		CENSUS SUMMARY	
Private Skilled	251	Private Skilled	251
Paid Bedhold	1	Private Intermediate	14,623
Non-paid Bedhold	0	Sheltered Care	0
Paid Discharge	0	Medicare	2,468
Private Intermediate	14,623	Medicaid	17,890
Paid Bedhold	182	V.A.	0
Non-paid Bedhold	0		
Paid Discharge	0	Total Patient Day:	35,232
Private Other	0	Bed hold Days	207
Paid Bedhold	0		
Paid Discharge	0	Total Days	35,439
Sheltered Care	0		
Paid Bedhold	0		
Paid Discharge	0		
Medicare	2,468	Medicaid Allocation:	
Paid Bedhold	0	Skilled (1/3)	5,963
Non-paid Bedhold	0	Intermediate (2/3)	11,927
Paid Discharge	0		
Medicaid	17,890	Medicaid Paid Bedhold	24
Paid Bedhold	24		
Non-paid Bedhold	0		
Paid Discharge	0		
V.A. days	0		
Total Days	35,439		

FACILITY NAME:	<u>Maryville Manor</u>	BEGINNING:	<u>1/1/01</u>
ID#:	<u>0038174</u>	ENDING:	<u>12/31/01</u>

**RELATED PARTIES**  
**DATA INPUT SHEET**

1	<b><u>Balance Sheet</u></b>	<b><u>Grouping</u></b> <b><u>Code</u></b>	<b><u>Facility</u></b> <b><u>\$</u></b> <b><u>Amount</u></b>	<b><u>RFMS</u></b> <b><u>Mngmnt</u></b> <b><u>Amount</u></b>	<b><u>Lessor</u></b> <b><u>Amount</u></b>	<b><u>Consoli-</u></b> <b><u>dated</u></b> <b><u>Total</u></b>
	Cash	A1	37,825	81,255	0	119,080
	Patient Deposits	A2	1,397	0	0	1,397
	Accounts Receivable	A3	585,653	425,795	0	1,011,448
	Prepaid Insurance	A6	135,701	27,491	0	163,192
	Other Prepaid Exp	A7	0	0	0	0
	Related Party Rec'ble	A8	0	1,574,571	0	1,574,571
	Interdivision Receivable	A9	2,577,451	0	0	2,577,451
	Interest Receivable	A9a	0	0	0	0
	Long-term Investments	B12	0	104,078	0	104,078
	Land	B13	0	0	81,250	81,250
	Buildings	B14	0	0	2,640,999	2,640,999
	Leasehold Improve	B15	68,645	134,810	115,420	318,875
	Equipment	B16	180,559	622,295	447,682	1,250,536
	Accum Depreciation	B17	(185,917)	(601,776)	(1,333,553)	(2,121,246)
	Deferred Maintenance	B18	0	0	0	0
	Org & Pre-Op Costs	B19	0	0	0	0
	Accum Amortization	B20	0	0	0	0
	Loan Financing Costs	B23a	0	0	0	0
	Leasehold Deposit	B23b	0	0	0	0
	<b>Total Assets</b>		<b>3,401,314</b>	<b>2,368,519</b>	<b>1,951,798</b>	<b>7,721,631</b>
	Accounts Payable	C26	69,080	34,290	0	103,370
	A/P-Patient Deposits	C28	1,397	0	0	1,397
	Short-Term Notes Pay	C29	0	0	0	0
	Accrued Salaries	C30	124,554	125,952	0	250,506
	Accrued Taxes	C31	3,172	0	0	3,172
	AccrRealEstateTax	C32	74,300	5,886	0	80,186
	Accrued Interest	C33	0	0	11,957	11,957
	Interdivision Payable	C36	0	0	0	0
	Other Current Liab	C37	0	0	0	0
	Mortgage Payable	D40	0	0	2,154,498	2,154,498
	Patient Deposits	D44	75,000	0	0	75,000
	Retained Earnings	E1	2,416,162	2,202,391	(214,657)	4,403,896
	Distributions	E13	0	0	0	0
	Transfers	E18	0	0	0	0
	<b>Total Liab &amp; Equity</b>		<b>2,763,665</b>	<b>2,368,519</b>	<b>1,951,798</b>	<b>7,083,982</b>
	<b>Net Income(Loss)</b>		<b>637,649</b>	<b>0</b>	<b>0</b>	<b>637,649</b>

2

<b>Lessor - Interest Expense</b>	<u>150,623</u>
<b>Lessor - Loan Fee Amortization</b>	<u>3,060</u>

FACILITY NAME:	<u>Maryville Manor</u>	BEGINNING:	<u>1/1/01</u>
ID #:	<u>0038174</u>	ENDING:	<u>12/31/01</u>

**ATTACHED SCHEDULE I**

**VII. RELATED NURSING HOMES**

<u>FACILITY NAME</u>	<u>CITY</u>
Care Center of Abingdon	Abingdon
Centralia Manor	Centralia
Jerseyville Manor	Jerseyville
Lawrenceville Manor	Lawrenceville
Leroy Manor	Leroy
Maryville Manor	Maryville
Parkway Manor	Marion
Pekin Manor	Pekin
Pittsfield Manor	Pittsfield
Seminary Manor	Galesburg
Shelbyville Manor	Shelbyville

<b><u>RECLASSIFICATION ENTRY</u></b>	Schedule and Line #	Total Per General Ledger (Column 4)	Reclass Increase or (Decrease) (Column 5)	Reclassified Total (Column 6)
(1) <b>To Allocate a % of Vehicle Expenses To Program</b>				
Program Transportation	V-14	2,354	902	3,256
Other Admin. Staff Transportation	V-25	1,804	(902)	902

**SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION**

<b>Care Related Vehicle Expenses:</b>	
Fuel and miscellaneous supplies	749
Repairs and maintenance	<u>1,055</u>
<b>Total vehicle expenses</b>	<u><u>1,804</u></u>



**FACILITY NAME:** Maryville Manor  
**ID #:** 0038174

**BEGINNING:** 1/1/01  
**ENDING:** 12/31/01

**ATTACHED SCHEDULE II**

**Bed Allocation**

<b>FACILITY NAME:</b>	<u>Maryville Manor</u>	<b>BEGINNING:</b>	<u>1/1/01</u>
<b>ID#:</b>	<u>0038174</u>	<b>ENDING:</b>	<u>12/31/01</u>

**ATTACHED SCHEDULE III**      Allocation of Related Party Administrative Service Costs

**SUMMARY SCHEDULE**

**Sch. V**      (See attached detail schedule)

Line #		Salaries	Other	Total
1	Dietary			0
2	Food Purchase			0
3	Housekeeping			0
4	Laundry			0
5	Heat & Other Utilities		325	325
6	Maintenance		467	467
7	Other			0
9	Medical Director			0
10	Nursing & Med Records			0
10A	Therapy			0
11	Activities			0
12	Social Services			0
13	Nurse Aide Training			0
14	Program Transportation			0
15	Other			0
17	Administrative	82,483		82,483
18	Directors Fees			0
19	Professional Services		2,885	2,885
20	Fees, Subs. & Pro.		14	14
21	Clerical & General		7,064	7,064
22	Employee Ben. & P/R		13,135	13,135
23	Inservice Training & Ed.			0
24	Travel & Seminar		3,912	3,912
25	Admin. Staff Transp.		3,198	3,198
26	Insurance		235	235
27	Other			0
30	Depreciation		3,049	3,049
31	Amortization of Pre-Op.			0
32	Interest		151	151
33	Real Estate Taxes		287	287
34	Rent-Facility & Grounds		3,909	3,909
35	Rent-Equip. & Vehicles		656	656
36	Other - Amortization			0
TOTALS		<u>82,483</u>	<u>39,287</u>	121,770

<div style="border: 1px solid black; padding: 2px;">19</div>	Amount per G/L - administrative services recorded as professional fees	(156,000)
	Net adjustment required	<u>(34,230)</u>

FACILITY NAME:	Maryville Manor	BEGINNING:	1/1/01
ID#:	0038174	ENDING:	12/31/01

**ATTACHED SCHEDULE III**

**Allocation of Related Party Administrative Service Costs  
DETAIL SCHEDULE**

ALLOCATION FACTORS	Total Y-T-D Beds	Facility Y-T-D Beds	Allocation Percentage		
ALL FACILITIES	33,156	1,440	4.3431%		
NURSING HOME FACILITIES	16,128	1,440	8.9286%		

  

	Total Costs Incurred	Non- Allowable Costs	Adjusted Costs	Allocated Costs	Schedule & Line Reference
<b>ALL FACILITIES:</b>					
Salaries - Owner	200,000		200,000	8,686	V-17
Salaries and wages	816,159	49,212	766,947	33,309	V-17
Advertising	317		317	14	V-20
Insurance	5,401		5,401	235	V-26
Payroll taxes & other benefits - Owner	37,441	23,970	13,471	585	V-22
Payroll taxes & other benefits	156,214	10,580	145,634	6,325	V-22
Utilities	8,579	1,089	7,490	325	V-5
Telephone	35,472		35,472	1,541	V-21
Building rental	90,000		90,000	3,909	V-34
Depreciation	70,200		70,200	3,049	V-30
Interest	3,481		3,481	151	V-32
Legal fees	13,898	6,364	7,534	327	V-19
Accounting fees	92,167	50,765	41,402	1,798	V-19
Outside management consultants	17,500		17,500	760	V-19
Supplies	100,911		100,911	4,383	V-21
Airplane & vehicle rental	15,098		15,098	656	V-35
Vehicle expense	15,156		15,156	658	V-25
Travel reimbursements	38,443	34,103	4,340	188	V-24
Meal expense	15,657	8,137	7,520	327	V-24
Training	4,985	2,350	2,635	114	V-24
Real estate taxes	6,612		6,612	287	V-33
Building & equipment maintenance	10,752		10,752	467	V-6
Other	28,403	28,403	0	0	V-21
Printing	4,030	48	3,982	173	V-21
<b>SUBTOTALS</b>	1,786,876	215,021	1,571,855	68,267	
<b>NURSING HOME FACILITIES:</b>					
Salaries and wages	453,471		453,471	40,488	V-17
Insurance	0		0	0	V-26
Payroll taxes & other benefits	69,718		69,718	6,225	V-22
Telephone	10,835		10,835	967	V-21
Vehicle expense	28,445		28,445	2,540	V-25
Vehicle lease	0		0	0	V-35
Travel reimbursements	21,672		21,672	1,935	V-24
Meal expense	2,792		2,792	249	V-24
Training	12,306		12,306	1,099	V-24
<b>SUBTOTALS</b>	599,239	0	599,239	53,503	
<b>TOTALS</b>	2,386,115	215,021	2,171,094	121,770	

**SUMMARY SCHEDULE**

Salaries - Administrative	82,483	V-17
Heat & Other Utilities	325	V-5
Maintenance	467	V-6
Professional Services	2,885	V-19
Fees, Subscriptions & Promotion	14	V-20
Clerical & General Office Exp.	7,064	V-21
Employee Benefits & P/R Taxes	13,135	V-22
Travel & Seminar	3,912	V-24
Other Admin. Staff Transp.	3,198	V-25
Insurance	235	V-26
Depreciation	3,049	V-30
Interest	151	V-32
Real Estate Taxes	287	V-33
Rent - Facility	3,909	V-34
Rent - Equipment & Vehicles	656	V-35
	39,287	
	121,770	

FACILITY NAME:	<u>Maryville Manor</u>	BEGINNING:	<u>1/1/01</u>
ID#:	<u>0038174</u>	ENDING:	<u>12/31/01</u>

ATTACHED SCHEDULE IV      **Related Party Cost Adjustment**  
**Facility Rent**

Cost to Related Party Lessor:			
Depreciation (Reported on Sch. XI)	128,286		V-30
Interest	150,623		V-32
Loan Fee Amortization	<u>3,060</u>		V-36
Total lessor cost	281,969		
Cost Per General Ledger - Facility Rent	415,949		V-34
Cost Adjustment Required	<u>(133,980)</u>		

Page 5, Line 10, Interest and Other Investment Income Adjustment

Allocation of Investment Income  
(Centralia Manor a/c #1929 & 1930)

Facility	Beds/Units	%	Allocated	Adjust
Centralia Manor	120	9.4637%	41,742	
Jerseyville Manor	84	6.6246%	29,219	
Lawrenceville Manor	123	9.7003%	42,786	
Leroy Manor	96	7.5710%	33,394	
Maryville Manor	120	9.4637%	41,742	41,742
Parkway Manor	119	9.3849%	41,394	
Pekin Manor	151	11.9085%	52,525	
Pittsfield Manor	105	8.2808%	36,524	
Shelbyville Manor	131	10.3312%	45,568	
Centralia Estates	39	3.0757%	13,566	
Liberty Estates	59	4.6530%	20,523	
Parkway Estates	42	3.3123%	14,610	
Pekin Estates	79	6.2303%	27,480	
Totals	<u>1,268</u>	<u>100%</u>	<u>441,074</u>	

Interest and Other Investment Income (Page 19, Line 25)	404
Required Adjustment (Page 5, Line 10)	<u>42,146</u>

FACILITY NAME: Maryville Manor  
ID #: 0038174

BEGINNING: 1/1/01  
ENDING: 12/31/01

**ATTACHED SCHEDULE V**

**PAGE 19, XVII. INCOME STATEMENT**

**Federal Income Tax Return Reconciliation:**

Income (loss) before income taxes (Line 41)		637,649
Nondeductible expenses:		
50% meal exclusion	146	
Fines and penalties	0	
Lobbying expenses	528	
		674
Timing differences:		
Depreciation expense - tax basis	(20,789)	
Depreciation expense - book basis	19,646	
Accrued vacation exp. - prior year	(35,153)	
Accrued vacation exp. - current year	30,336	
		(5,960)
Taxable income (loss)		632,363

FACILITY NAME: Maryville Manor  
ID#: 0038174

BEGINNING: 1/1/01  
ENDING: 12/31/01

ATTACHED SCHEDULE VI

SCHEDULE V - COST CENTER EXPENSES

LINE 27 - OTHER:

Bad Debts	13,227
Lobbying	528
Total	<u>13,755</u>

ATTACHED SCHEDULE VII

SCHEDULE VI - ADJUSTMENT DETAIL

LINE 29 - OTHER:

Out-of-state Training	V-24	1,276
Lobbying	V-27	528
Activity fund income	V-11	<u>0</u>
Total		<u>1,804</u>

ATTACHED SCHEDULE VIII

Page 17, XV. BALANCE SHEET

	Operating	After Consolidated
Line 9, Other Current Assets:		
Interdivision Receivable	2,577,451	2,577,451
Interest Receivable	<u>0</u>	<u>0</u>
Total	<u>2,577,451</u>	<u>2,577,451</u>

ATTACHED SCHEDULE IX

Page 18, XVI. STATEMENT OF CHANGES IN EQUITY

Line 4, Restatements:

Uncollectible patient accounts	0
Medicare cost report settlements	0
Related party accrued interest income	0
Workers' comp insurance	0
Miscellaneous	0
Illinois replacement tax	<u>0</u>
Total	<u>0</u>

Restatements are year end adjustments which were made subsequent to the preparation of the Medicaid cost report for the prior year. The equity balance at the beginning of the year, restated by the above adjustments, agrees with the financial statements.

**FACILITY NAME:** Maryville Manor  
**ID#:** 0038174

**BEGINNING:** 1/1/01  
**ENDING:** 12/31/01